DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: The Summit Assisted Living

DATE SURVEY COMPLETED: March 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility beginning February 3, 2017 and ending March 3, 2017. The facility census on the entrance day of the survey was 74 residents. The survey sample totaled 9 residents and was composed of 7 residents plus a subset of two residents. The survey process included observations, interviews and review of resident clinical records, facility documents and facility policies and procedures. **Abbreviations used in this state report are as follows:** **ED - Executive Director** **DON - Director of Nursing** **ADON – Assistant Director of Nursing** **RN - Registered Nurse** **LPN - Licensed Practical Nurse** **CNA – Certified Nurse Aide** **UAI – Uniform Assessment Instrument - an assessment form used to collect information about the physical condition, medical status and psychosocial needs of an applicant/resident in order to determine eligibility for an assisted living facility.** **UAP – Unlicensed Assistive Personnel – an unlicensed staff member who receives training in order to assist with the administration of medications or administer medications in assisted living facilities.** **Assisted Living Facilities**		

Provider's Signature _____ Title Exec. Director Date 8/23/17

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3225.0 3225.8.0 3225.8.1 3225.8.1.5	**Medication Management** **An assisted living facility shall establish and adhere to written medication policies and procedures which shall address:** **Provision for a quarterly pharmacy review conducted by a pharmacist which shall include:** **This requirement is not met as evidenced by:** Based on record reviews and staff interviews it was determined that the facility failed to conduct and document quarterly pharmacy reviews for two residents (R1 and R7) out of nine residents sampled. Findings include: 1. R1 was admitted to the assisted living facility on May 3, 2016. Review of the clinical record revealed no documentation of the first quarterly pharmacy review between May 2016 and August 2016. Instead the first documented quarterly pharmacy review for R1 was dated October 6, 2016. According to the facility policy "Medication Regimen Review "a... Consultant Pharmacist will document any on-site Medication Regimen Reviews in the 'Chronological Record of Medication Regimen Reviews'". These findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) on 2/16/2017 at 3:40 PM. 2. R7 was admitted to the assisted living facility on August 31, 2015. Review of the clinical record revealed no documentation of quarterly pharmacy	**3225.8.1.5** A. A review of R1 quarterly reviews have been completed with no negative outcome identified for either resident from the deficient practice. All further pharmacy reviews were completed within appropriate time frames. B. The community completed an audit of all current residents to verify that quarterly pharmacy reviews were conducted within scheduled time frames. C. Communication system/policy between the community and consultant pharmacist were evaluated. As a result of this evaluation systematic changes were implemented to ensure the timeliness of reviews. D. DON/designee will conduct monthly audits until 100% compliance is reached over 3 consecutive evaluations. Finally, the DON/designee will conduct quarterly audits	04/21/17

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	reviews between August 31, 2015 and January 25, 2016. Instead the first documented quarterly pharmacy review for R7 was dated January 25, 2016. According to the facility policy "Medication Regimen Review "a... Consultant Pharmacist will document any on-site Medication Regimen Reviews in the 'Chronological Record of Medication Regimen Reviews'". These findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) on 2/16/2017 at 3:40 PM.	until 100% compliance is achieved over 2 consecutive evaluations. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will be randomly conducted annually to assess continued compliance with review time frames. The results of the audits will be reviewed and reported to the community QA committee quarterly.	
3225.8.8 **3225.8.8.2**	**Concurrently with all UAI-based assessments, the assisted living facility shall arrange for an on-site review by a registered nurse, for residents who need assistance with self-administration or staff administration of medication, to ensure that:** **Each resident receives the medications that have been specifically prescribed in the manner that has been ordered;** **This requirement is not met as evidenced by:** Based on observation of medication administration, clinical record reviews and staff interviews it was determined that the facility failed to ensure that two residents (RSS1 and RSS2) out of nine residents sampled received medications as prescribed by the physician. Findings include: 1. Observation of the administration of an eye medication on 2/14/2017 at 8:50 PM by E10 (CNA/UAP) revealed that RSS1 had not received the dosage as prescribed by her physician. E10 administered two drops of an eye medication in each eye of RSS1instead of one drop prescribed	A. A review of R7 quarterly reviews have been completed with no negative outcome identified for either resident from the deficient practice. All further pharmacy reviews were completed within appropriate time frames. B. The community completed an audit of all current residents to verify that quarterly pharmacy reviews were conducted within scheduled time frames. C. Communication system/policy between the community and consultant pharmacist were evaluated. As a result of this evaluation systematic changes were implemented to ensure the	

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	for each eye as prescribed by RSS1's physician. According to the label of the eye medication, Systane, one drop was prescribed for administration in each eye once a day for RSS1. Review of the medication label and electronic Medication Administration Record (MAR) dated February 2017 revealed that the prescribed dosage was consistent with the physician's order. The facility failed to ensure that a medication prescribed by the physician for RSS1 was properly administered according to the medication label, electronic MAR dated 2/2017 and the physician order at 8:50 AM on 2/14/2017. These findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) on 2/16/2017 at 3:40 PM. 2. Medication observation conducted on 2/14/2017 revealed that E10 failed to create the correct mixture of a prescribed medication and water for administration to RSS2 according to the physician's order. Review of the electronic MAR dated 2/2017 and the medication label revealed consistency of the medication ordered and the amount of liquid needed to prepare the mixture. The medication label read "Miralax 17 gm (gram: a unit of measure) Oral Powder (used to treat occasional constipation), one scoopful by mouth every day, one time a day. Give 17 gms mixed in 4 to 8 ounces of any beverage of choice." During preparation of the mixture E10 accurately measured the powder in the medication cap specifically designed for this purpose. Next she poured the medication powder into a 12 ounce Styrofoam cup then added an amount of water she estimated to be approximately 9 ounces using a plastic cup without any markings for measurement and added it also to the 12 ounce	timeliness of reviews. D. DON/designee will conduct monthly audits until 100% compliance is reached over 3 consecutive evaluations. Finally, the DON/designee will conduct quarterly audits until 100% compliance is achieved over 2 consecutive evaluations. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will be randomly conducted annually to assess continued compliance with review time frames. The results of the audits will be reviewed and reported to the community QA committee quarterly. **3225.8.8.2** A. No negative outcomes were identified for residents RSS1. B. All residents have the potential to be affected by the deficient practice. C. E10 was re-educated on the administration of eye medication.	3/31/17

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	Styrofoam cup. E10 had informed this surveyor that the plastic cup measured 6 ounces and had filled the "6" ounce cup initially with "6" ounces of water and then refilled it with additional water estimated as less than 3 ounces and added all the poured water to the 12 ounce cup to mix with the Miralax Oral Powder. Observation of the medication administration also revealed that RSS2 asked E10 if he needed to finish all of the Miralax Oral Powder mixture because it was too much to drink and she responded "yes". In an interview with E3 (ADON) conducted on 2/14/2017 at approximately 11:15 AM this surveyor was informed that the plastic cup used by E10 to fill with water and add to the Miralax Oral Powder was actually a 9 ounce cup. E3 further stated that the 9 ounce cup size was the only cup supplied to the nursing unit. This finding was confirmed when this surveyor observed the unopened packaging of a sleeve of cups labeled 9 ounces. E3 also confirmed that the 9 ounce size cups lacked markings for accuracy in measurement. These findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) on 2/16/2017 at 3:40 PM. **Food service complies with the Delaware Food Code** **Hygienic Practices** **Hygienic Practices** **Hair Restraints** **Effectiveness** **(A) Except as provided in ¶ (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair**	D. DON/designee will conduct audits 3 times per week until 100% compliance is achieved over 2 consecutive weeks. Then the DON/designee will conduct audits once per week until compliance is achieved over 3 consecutive evaluations. Finally the DON/designee will conduct an audit 1 month later. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will occur at least annually as part of the QA monitoring plan. A. No negative outcomes were identified for residents RSS2. B. All residents have the potential to be affected by the deficient practice. C. E10 was re-educated on the administration of medication with specified fluids/amounts. Nursing completed a root cause analysis on the identified medication error. As a result of the identified root cause the community transitioned to the use of cups with measurement markings for use with medication	
3225.12.1.3 **2-4** **2-402** **2-402.11**			

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	coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. ***This section does not apply to FOOD EMPLOYEES such as counter staff who only serve BEVERAGES and wrapped or*** **PACKAGED** ***FOODS, hostesses, and wait staff if they present a minimal RISK of contaminating exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLEUSE ARTICLES.*** **This requirement is not met as evidenced by:** Based on observation and interview, the facility failed to ensure that hair and beard restraints (for men with facial hair) were worn in the kitchen to prevent contamination of food and clean equipment and utensils. Findings include: On 2/6/17 between 11:05 AM and 11:45 AM, servers E22, E23, E24, E25, and E26 were observed entering the kitchen multiple times, to place residents' lunch orders in the computer system by the steam table with hot foods, pick up meal trays, and retrieve other items for their assigned dining room. While in the kitchen, not one of the servers was observed with a hair restraint on. On 2/7/17 at 1:50 PM, E27 [cook], who wore a full beard, was observed in the kitchen wearing a hair restraint, but not a beard restraint.	administration. D. DON/designee will conduct audits 3 times per week until 100% compliance is achieved over 2 consecutive weeks. Then the DON/designee will conduct audits once per week until compliance is achieved over 3 consecutive evaluations. Finally the DON/designee will conduct an audit 1 month later. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will occur at least annually as part of the QA monitoring plan. **3225.12.1.3** **2-402.11** A. No residents were identified as being affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. C. Culinary Services Manager re-educated staff on the requirement for the use of hair and beard restraints. As a result of the root cause analysis systems were modified to include monitoring (pre-meal	3/31/17

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	In an interview on 2/7/17 at 2:00 PM, E20 [Director of Culinary Services] agreed that hair restraint around exposed food was necessary to prevent food from contamination. E20 also added that E27 always wore a beard restraint and could not understand how he could have forgotten it this time. These findings were reviewed with E1 [ED] and E20 on 2/7/17 at 2:30 PM. **Gloves, Use Limitation** **(A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.** **This requirement is not met as evidenced by:** Based on observation and interview, the facility failed to ensure that staff changed the gloves worn during preparation of dirty equipment and utensils for washing, before handling cleaned wares coming out of the dishwasher to be put away. Findings include: On 2/6/17 at 11:45 AM, E21 [dishwasher] was observed wearing gloves, preparing dirty equipment and utensils for dishwashing by stacking them in racks and hosing down dirt on surfaces, before putting them through the dishwasher. As the racks with cleaned wares came out, E21 grabbed the racks, held each equipment to check for cleanliness and began to put them away, wearing the same gloves.	review/meeting) and reinforcement of requirements throughout the meal service process by the Dining Room Manager/designee. D. Culinary Services Manager/designee will conduct daily audits until 100% compliance is reached over 3 consecutive evaluations. Then the Culinary Services Director/designee will conduct audits weekly until 100% compliance is reached over 3 consecutive evaluations. Then the Culinary Services Director/designee will conduct audits monthly until 100% compliance is reached over 3 consecutive evaluations. Finally the Culinary Services Director/designee will conduct an audit one month later. If 100% compliance is achieved, the facility will conclude the deficiency has been corrected and the audit will occur at least annually as part of the Culinary Services QA monitoring plan.	

Provider's Signature D. Bell Title Exec. Director Date 8/18/17

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3225.19.6	In an interview on 2/7/17 at 2:00 PM, E20 [Director of Culinary Services] concurred that gloves should be changed between tasks, so that gloves worn for use with dirty equipment were not used again for cleaned equipment. These findings were reviewed with E1 [ED] and E20 on 2/7/17 at 2:30 PM. **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** **This requirement is not met as evidenced by:** Based on review of clinical records, review of facility incident reports and staff interviews it was determined that the facility failed to immediately report within 8 hours to the Division the transfer of one resident (R1) out of nine residents sampled to an acute care facility. The facility also failed to immediately report two incidents, an elopement and an incident of substantiated negligence, involving one resident (R3) out of nine residents sampled within 8 hours to the Division. Findings include: 1. Review of the clinical record revealed a nurse's note dated 7/2/2016 and timed 11:39 that addressed a fall sustained by R1 as he stood up from his chair, losing his footing while turning and fell to the floor striking his head against the wall. R1 was sent to an acute care facility by his physician for evaluation and treatment. Review of the facility incident report revealed that the facility failed to report the incident to the Division after R1 was transferred to an acute care facility for evaluation and treatment after a fall.	A. No residents were identified as being affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. C. Culinary Services Manager re-educated identified staff on the requirement for the proper use of gloves when working between clean and soiled environments. D. Culinary Services Manager/designee will conduct daily audits until 100% compliance is reached over 3 consecutive evaluations. Then the Culinary Services Director/designee will conduct audits weekly until 100% compliance is reached over 3 consecutive evaluations. Then the Culinary Services Director/designee will conduct audits monthly until 100% compliance is reached over 3 consecutive evaluations. Finally the Culinary Services Director/designee will conduct an audit one month later. If 100% compliance is achieved, the facility will conclude the deficiency has	

Provider's Signature D. L. Bell Title Exec. Director Date 8/18/17

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	Additionally a review conducted on 2/27/2017 of documents submitted by the facility to the Division revealed the absence of a report of the above referenced incident. The facility failed to immediately report an incident of the transfer of R1 to an acute care facility for evaluation and treatment following a fall. These findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) on 2/16/2017 at 3:40 PM. 2a. Review of a facility incident report submitted to the Division on 3/14/2016 at 2:51 PM revealed it was received approximately 41 hours after R3 was found on 3/12/2016 at approximately 10:11 PM outside of the facility seated on the ground proximal to the fire door and without the knowledge of staff. An investigation of the incident conducted by the facility included reviews of security cameras located on the dementia unit that revealed a visiting family member of another resident held the door open permitting R3 to leave the unit at 8:15 PM and wander outside the front door of the facility at 8:20 PM on 3/12/2016 and without the knowledge of staff. At 10:11 PM R3 was found outside of the facility by a security guard. R3 was returned inside the facility and placed in the dementia unit. The facility failed to immediately report an incident of elopement by R3 who was missing approximately two hours without the knowledge of staff. R3 was found outside the facility and returned inside the facility by a security guard. These findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) on 2/16/2017 at 3:40 PM. 2b. A completed facility investigation of an elopement from the facility by R3 on 3/12/2016	been corrected and the audit will occur at least annually as part of the Culinary Services QA monitoring plan. **3225.19.6** A. R1 returned to the community with no new orders. B. A review of incident reports for the past 30 days was completed in order to identify any incidents that were not reported timely and corrective action taken if necessary. There were no findings based on the review. C. The DON/designee will inservice Nursing Supervisors on community investigative protocol and reporting requirements/processes. The reporting process responsibility has been expanded to additional members of the nursing management team with oversight by the DON/designee. Incident occurrences and investigations will be reviewed at the community's morning meeting to evaluate compliance with proper	4/17/17

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3225.19.7.2	also referred to documented hourly checks that occurred without observation of the physical presence of R3 at 9:00 PM. According to the above referenced investigation R3 was returned to the facility at approximately 10:11 PM when found on the facility grounds by a security guard. Additionally review of camera footage revealed that R3 eloped from the facility at 8:20 PM. A review conducted on 3/2/2017 of documents submitted by the facility to the Division revealed the absence of a report and investigation of the above referenced incident. The facility policy "Reportable Incidents" states that reportable incidents are to be reported immediately and within 8 hours to the Division. Further review of the facility policy revealed "Neglect" as a reportable incident. The facility failed to immediately report an incident of substantiated neglect involving R3. These findings were reviewed with E1 (ED) on 3/3/2017 at approximately 2:05 PM. **Reportable Incidents include:** **Neglect as defined in 16 Del.C. Section 1131** **Del., C., Chapter 11, Subchapter III** **Section 1131. Definitions.** **When used in this subchapter, the following words shall have the meaning herein defined. To the extent the terms are not defined herein, the words are to have their commonly-accepted meaning.** **(10) "Neglect" shall mean:** **a. Lack of attention to physical needs of the patient or resident including, but not limited to**	reporting procedures. The DON/designee will maintain an incident report log which documents compliance with State reporting requirements. D. The DON/designee will conduct audits 3 times per week until compliance is achieved over 3 consecutive evaluations. Then the DON/designee will conduct audits once per week until compliance is achieved over 3 consecutive evaluations. Then the DON/designee will conduct audits monthly until compliance is achieved over 3 consecutive evaluations. Finally the DON/designee will conduct an audit 1 month later. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will occur at quarterly as part of the QA monitoring plan. A. R3 no longer resides at the community. B. A review of incident reports for the past 30 days was completed in order to identify any incidents that were not reported timely and corrective action taken	

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	toileting, bathing, meals and safety. **This requirement is not met as evidenced by:** Based on review of the clinical record, facility documents and staff interview it was determined that the facility failed to ensure documentation was accurate for one resident (R3) out of nine sampled who had eloped from the facility. Findings include: Clinical record review revealed that R3 was admitted to the assisted living facility on 12/10/2015 with diagnoses that included dementia (loss of mental functions such as memory loss and reasoning that is severe enough to interfere with a person's daily functioning.) According to the initial Uniform Assessment Instrument (UAI) dated 12/2/2015 R3 was oriented to person only and experienced short- term memory and long- term memory problems. Review of the same UAI dated 12/2/2015 also revealed that R3 required standby assistance during transfers; supervision, complete assistance for grooming and supervision or set up or cueing and coaching for dressing. The section of the UAI dated 12/2/2015 and labeled "Fall Risk Assessment" identified R3 at risk for falls due to impaired balance. A cane to assist R3 with ambulation was also documented in the above referenced UAI. Further review of the clinical record revealed a nurse's note dated 3/12/2016 and timed 1:46 AM that stated R3 was found sitting on the ground outside of the facility by the evening security guard at 10:11 PM. The nursing note further stated that although E7 (CNA) acknowledged she had observed R3 on the dementia unit during hourly checks prior to learning of her elopement she also "looked" all over the (dementia) unit without locating R3 and documented an hourly	if necessary. There were no findings based on the review. C. The DON/designee will inservice Nursing Supervisors on community investigative protocol and reporting requirements/processes. The reporting process responsibility has been expanded to additional members of the nursing management team with oversight by the DON/designee. Incident occurrences and investigations will be reviewed at the community's morning meeting to evaluate compliance with proper reporting procedures. The DON/designee will maintain an incident report log which documents compliance with State reporting requirements. D. The DON/designee will conduct audits 3 times per week until compliance is achieved over 3 consecutive evaluations. Then the DON/designee will conduct audits once per week until compliance is achieved over 3 consecutive evaluations. Then the DON/designee will conduct audits monthly until	

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	check at 9:00 PM in R3's absence. Review of the Incident report dated 3/12/2016 and timed 10:45 PM revealed R3 stated that "she was attempting to go home." She (R3) was "found at 10:11 PM, after the 8:00 PM rounds she was noted missing." An investigative report of the Incident dated 3/12/2016 revealed that R3 was brought into the building by nursing staff when the resident was found by the security guard. While reviewing camera footage of the facility, E2 [DON] noted a visitor of another resident who was leaving the unit held the door open for R3 who exited the unit around 8:15 PM and eventually walked unobserved through the front door at 8:20 PM. Results of disciplinary action initiated 3/17/2016 revealed that E7 falsely documented that R3 was seen and safe at 9:00 PM on 3/12/2017 although the resident had eloped from the facility at 8:20 PM and was found outside of the facility at 10:11 PM. These findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) on 2/16/2017 at 3:40 PM.	compliance is achieved over 3 consecutive evaluations. Finally the DON/designee will conduct an audit 1 month later. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will occur at quarterly as part of the QA monitoring plan. **3225.19.7.2** A. R3 no longer resides at the community. B. A focused review of incident reports, along with associated care documentation for the past 30 days was completed in order to identify any potential discrepancies/inaccuracies with corrective action taken if necessary. There were no findings based on the review. C. A root cause analysis was completed by nursing including policies and procedures related to documentation of care. No required changes/modifications were identified.	4/24/17

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		D. The DON/designee will conduct incident report and associated care audits 3 times per week until compliance is achieved over 3 consecutive evaluations. Then the DON/designee will conduct audits once per week until compliance is achieved over 3 consecutive evaluations. Then the DON/designee will conduct audits monthly until compliance is achieved over 3 consecutive evaluations. Finally the DON/designee will conduct an audit 1 month later. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will occur at quarterly as part of the QA monitoring plan.	

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